

Verification of Licensure in Marriage and Family Therapy

Part I - TO BE COMPLETED BY APPLICANT

Applicant's

Name _____
Last First Middle Maiden(if applicable)

Address _____
Street City State Zip

Type of License License # Date First Issued Expiration Date

Authorization to release information: I hereby authorized

_____ to release
(Name of Agency)

the information requested below.

Applicant's Signature Date

Part II - TO BE COMPLETED BY LICENSURE BOARD

Verification of Licensure: This is to certify that the above-named applicant was issued license or certificate number _____ on date _____ entitling her/him to use the title Marriage and Family Therapists and/or the right to practice marriage and family therapy.

Current Status: Active _____ Inactive _____ Lapsed _____ Suspended _____

The license was granted on the basis of: Graduated degree with clinical experience _____,

State examination, _____ Endorsement with license from the State of _____

_____.

1. At the time of licensure was this applicant required to pass an examination, the content of which tested competence to practice marriage and family therapy? Yes No
2. At the time of licensure, did this applicant show proof of have a graduate degree in marriage and family therapy? Yes No
3. At the time of licensure, did this applicant show proof of at least two years of clinical

- practice under supervision in marriage and family therapy? Yes No
4. Has this license ever been encumbered in any way (suspended, revoked, surrendered, restricted, limited, or placed on probation)? Yes No
5. Are there any complaints pending against this applicant? Yes No
6. Do your agency records concerning this applicant contain any information that is derogatory in nature? Yes No
7. Do you know of any reason why this individual would be unable to practice marriage and family therapy with reasonable skill and safety to the residents of the State of Mississippi due to any mental or physical condition, illness, or use of alcohol, drugs, narcotics, chemicals or any other type of material? Yes No

If you answered "YES" to any of the questions 4 through 7 above, please explain.

Signature _____ Date _____

Title _____

State Board _____

Address _____

Street or P.O. Box

City _____ State _____ Zip _____

Thank you for your assistance.

Please return this form to the Board at the following address:

**MS Board of Examiners for SW/MFT
Post Office Box 4508
Jackson, MS 39296-4508**